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Older Adults Are Spending Too Long in the ED—Here's Why and What Could Help

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With beeping monitors, hurried footsteps, and bright lights all teeming with urgency, emergency departments (EDs) can be overwhelming for anyone. But for older adults, every hour spent in an ED can increase the risk of immobility and delirium.

"Precipitants of delirium in older adults are disruptions in sleep, immobility, and change of environment," said Maura Kennedy, MD, MPH, division chief of geriatric emergency medicine at Massachusetts General Hospital. "If you think about an environment that is most likely to disrupt someone's sleep, I think the emergency department, from a hospital perspective, is that environment."

Delirium is so important that, as of this year, the Centers for Medicare & Medicaid Services (CMS) requires hospitals to attest to their procedures for containing ED length of stay to 8 hours and boarding time to 3 hours for a percentage of older adults. The time standards are based on previous research and recommendations, Kennedy noted, and are a part of CMS's Age-Friendly Hospital Measure, which seeks to improve the quality of care provided to the US's aging population.

With these benchmarks in mind, researchers recently examined trends in older adults' ED stays, and what they learned was troubling. The study, published this June in *JAMA Internal Medicine*, found a substantial increase in the proportion of adults with prolonged length of stay and boarding times over the past 8 years. Based on health records from more than 1600 hospitals and 295 million adults aged 65 years or older, 20% of ED patient encounters had a length of stay of more than 8 hours at the end of 2024, an 8-percentage-point increase from the start of 2017.

ED lengths of stay may be prolonged for thorough medical evaluations. But boarding times—the wait between the decision to admit and the actual admission to an inpatient bed—are determined by bed capacity and other hospital-level factors. The new analysis detected a 14-percentage-point increase in older adults' boarding times exceeding 3 hours, rising to more than 1 in 3 visits, over the same study period.

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"If [these numbers are] not surprising, then we better do a little moral checkup on ourselves and decide how we got okay with this state of affairs," said Kevin Biese, MD, MAT, director of the division of geriatric emergency medicine at the University of North Carolina at Chapel Hill School of Medicine and coauthor with Kennedy of an invited commentary on the study. "I think it's causing a lot of harm collectively."

Complex Drivers

This trend toward longer stays appears to be coinciding with more ED visits for older adults. In 2022, the number of visits for the top 10 diagnoses was about 33 million for people aged 65 years or older, compared with about 23 million in 2016, according to the US Centers for Disease Control and Prevention. Meanwhile, a recent study predicted that the US may reach the threshold for a full-blown hospital bed shortage by 2032, which would likely further lengthen ED boarding times.

The new study found a small decline in the rates of prolonged ED stays and boarding after the COVID-19 pandemic. But the larger patterns, coupled with the aging US population and workforce shortages, lead experts to believe that conditions will only get worse.

"We know that the health care workforce has changed as a result of COVID—lots of people left health care, and hospital business models have evolved to some degree," said Adrian Haimovich, MD, PhD, director of geriatric emergency medicine at Beth Israel Deaconess Medical Center and a coauthor of the study. "I don't know that we're going to get back to pre-COVID levels of these things, which were, by the way, not good."

EDs at academic hospitals had even greater increases in both long length of stay and boarding times in the new study. In these settings, the proportion of prolonged stays increased from 19% to 30% while the share of prolonged boarding times rose from 31% to 45%.

One reason for this may be that academic hospitals often also have cancer centers or specialty surgical centers whose

planned inpatient admissions reduce the number of available beds, Kennedy noted. In addition, these hospitals often provide more complex care than other health systems.

As Haimovich pointed out, boarding is a hospital issue, not an ED issue.

"We know that the challenge is getting patients up out of the ED into hospital beds that don't exist or aren't staffed," he said.

Still, there are good reasons why this backup can happen, especially at certain times of day when it may be safer to keep a patient in the hospital. Clinical staff may not want to discharge an older patient late at night if they don't have a ride home, for example. But this may be the worst time for the admission process to slow down. Research has found that the risk of mortality and adverse events increases when older adults spend the night in the ED waiting for a hospital bed.

Additionally, a lack of capacity in post-acute care centers or insurance barriers to transferring patients to these centers, both of which can stall hospital discharging, may trickle down to the ED, Haimovich and his co-authors suggest.

"Misaligned incentives" are also driving the trend toward limited hospital bed availability, the commentary authors say. Hospitals receive financial benefits from high inpatient occupancy and from reserving beds for "lucrative elective admissions and surgeries over lower-margin ED admissions," they wrote.

But, Kennedy argues, these choices keep the lights on.

"Hospitals aren't making these decisions because they're greedy—they're making these decisions because these are the things that are financially viable," she said. "We have seen so many hospitals close because of the financial landscape," she added, citing declining reimbursements alongside growing costs for staffing and equipment.

Whatever the reasons, prolonged ED stays feed a worrying cycle. When hospital beds are occupied, ED boarding times are longer, which in turn increases the likelihood of delirium or mobility issues for older patients. This ups the chances of prolonged inpatient stays, which then leads to more occupied beds, and so on, Kennedy explained.

If the issue sounds complicated, she says that's because it is. And addressing it is going to require a multipronged approach.

Racing Against the Clock

Although CMS's Age-Friendly Hospital Measure aims to mitigate these long stays, experts say it alone cannot fix the hospital capacity issue. Instead, they recommended working through and expanding preexisting systems.

"The simplest solution would be to build hundreds upon hundreds of hospitals…that's just not a financially viable or technologically viable solution," Kennedy said. "We have to think, 'What are our opportunities to provide the care for our patients that don't involve the emergency [department]?' I think some of those opportunities are currently available and can be built up."

One of these models that she thinks has potential is the hospital-at-home program, through which clinicians provide hospital-level care at a patient's residence. The program has been shown to save lives, and is more cost-effective than an ED visit for certain conditions.

Another option to leverage is the CMS Program for All-Inclusive Care for the Elderly (PACE), which has been associated with lower rates of hospitalizations and ED visits. The initiative provides all-encompassing care for older adults, especially those struggling with frailty who would otherwise need to be in a long-term care facility or nursing home. Although it's typically only available to patients who are dual-eligible for Medicare and Medicaid, and most states have income and asset caps for the program, Kennedy suggested it could be expanded to enable more older adults to continue to live within their community and reduce their need for emergency care. But she cautioned that cuts to Medicaid might result in decreased federal support for PACE.

Haimovich also noted that hospital bed capacity may be flexed by increasing nursing staff or hallway boarding for inpatient beds.

But ultimately, fixing the issue will need a system-wide approach that moves beyond hospital walls.

"I don't really believe, as an ED physician, that there's a ton that we can do…to move patients through more quickly," Haimovich said. "This is a multi, multilevel problem and a very complicated one." ■

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Conflict of Interest Disclosures: Dr Kennedy reported receiving compensation for roles with the American College of Emergency Physicians (ACEP) geriatric ED accreditation program and being the immediate-past president for the organization's Geriatric Emergency Medicine Section. Dr Biese reported being the founder of ApogeeCare and a medical advisor to Third Eye Health; serving on the board of West Health Policy; serving as chair of the Board of ACEP Geriatric Emergency Department Collaborative; and being the University of North Carolina principal investigator for the Geriatric Emergency Department Collaborative, which receives funding from John A. Hartford and West Health Foundations. Dr Haimovich reported that his funding for the project discussed in this article was supported by National Center for Advancing Translational Sciences grant K12TR004381 via Harvard Catalyst. No other disclosures were reported.

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